**Budget issues driving/affecting treatment choice:   
Community involvement in the London ARV tender 2011/12**

Simon Collins, HIV i-Base

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**Background 1**

• In the UK, drug prices are negotiated locally and regionally, not nationally

• In London, for at least ten years, health trusts and hospitals have collaborated for drug purchasing

• Outcomes included lower prices and greater equity of prescribing across London

• Oversaw careful use of highest cost ARVs – usually for people with drug resistance

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**Background 2**

• Coordinating London-wide services also included New-Fill clinics for lipoatrophy minimising need for people to switch clinics

• From 2010, central government flat-lined NHS budgets – no increase for inflation. London HIV services had to find £8m savings from drug costs over two years

• Incentive was to be able to retain savings each year for local HIV services (specialist pharmacy, support nurses etc)

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**Tender process**

• Decision to tender ARV contracts, prices linked to volume use: bulk discounts

• Policy supported by doctors, community, etc

• Prescribing guidelines would then factor cost when recommending preferred first, second and MDR combinations

• When two similar drugs had significantly different prices, use the least expensive

• Unethical to routinely pay higher prices given limited budgets when not supported by data

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**Efficacy and safety vs cost**

• Prioritised efficacy and safety over cost

• Specialist advisory group developed guidelines: included leading HIV doctors and pharmacists from each health Trust and/or hospital, activists and HIV positive community reps.

• Less effective drugs (ie AZT, d4T) were never recommended even if they were cheaper

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**Timeline**

August 2010 Tender process announced after

involvement of key stakeholders

October 2010 Company meetings on the process

December 2010 Tender deadline

Jan-Mar 2011 Guidelines developed

1 April 2011 New guidelines in place

All steps included community involvement.

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**Recommendations**

• Mainly affected <50% of first-line treatment

• Abacavir/3TC > tenofovir/FTC when clinically appropriate

• No nuke-switches for stable patients

• Atazanavir/r as first line PI, some switching

• Higher cost ARVs for resistance/complications

• All ARVs could still be prescribed

• Approx £5m saved in year one

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Issues raised

• Some community groups and doctors, felt excluded from the process (even though this was publicised and open)

• Also strong support because of NHS crisis: ie okay to increase pill count but not doses

• Some media reports drove alarmist concerns

• Community responses included a safety audit, and clinic questionnaire and separate UK-CAB online survey

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**Inaccurate reporting**

Alarmist and inaccurate reporting included that:

• everyone would have to switch

• switching was to older worse drugs

• only the cheapest drugs were being used

• that patients had not been consulted.

None were true. These claims increased patient anxiety and worry.

The guidelines allowed for individual flexibility.

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**UK-CAB survey**

Online community survey (Nov11 – Jun 12) to see whether the guidelines:

1)  Were generally safe and effective.

2)  Were not resulting in reduced care,

3)  Were being interpreted correctly in all clinics and populations.

20 questions: broadly positive: ie “How has the new treatment affected your health?”: 57% no difference and 27% health improved. 15% thought their health had got worse (complex cases, or switched back and resolved).

Examples of bad care were related to poor clinical practice rather than from following the guidelines

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**Audit 1: patient questionnaire (n=146)**

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**Audit 2: responses by regimen (n=146)**

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**Implications**

• Could this be repeated?

• Unclear what would have happened if preferred ARVs were more expensive: lucky that preferred drugs tendered best prices

• Unclear whether roll-over after initial two-year contract will work

• Will other regions use similar approach?

• Can this work on national level?

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**Lessons**

• Significant outcome for public provider to get drug manufacturers to reduce prices to save £5m

• Often improved care (switching to PIs with fewer pills, side effects and lower RTV dose)

• Communication could have been better and evidence base for changes was not clear

• Audit was slow, but preliminary results support safety and patient satisfaction

• Community involvement at all stages was essential but problems still occurred

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**Further information**

London HIV commissioners

[www.londonscg.nhs.uk/](http://www.londonspecialisedcommissioning.nhs.uk/)

Community reports: i-Base.info & aidsmap.com

Community survey: www.UKCAB.net

Open access paper: Maintaining cost-effective access to ARV therapy through a collaborative approach to drug procurement, consensus treatment guidelines and regular audit: the experience of London HIV commissioners and providers.

Foreman C et al. Sex Transm Infect 2012;88:112-115

<http://sti.bmj.com/content/88/2/112.full>